FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035832

Facility Name: WEDGEWOOD NURSING PAVILION

Address: 8001 S. WESTERN AVE. (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 674-4733

IDPA ID Number: 36-3672749

Date of Initial License for Current Owners: 11/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	220	Skilled (SNF)	220	80,520	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,528	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	120,048	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,569	80	1,096	21,745	8
9	SNF/PED					9
10	ICF	83,003	397	357	83,757	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	103,572	477	1,453	105,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 87.88%

D. How many bed-hold days during this year were paid by Public Aid? 2,046 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started _____

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 944

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,550	37,878	7,368	353,796		353,796	0	353,796			1
2	Food Purchase		436,384		436,384	(28,328)	408,056	(4,955)	403,101			2
3	Housekeeping	259,930	50,603	0	310,533		310,533	0	310,533			3
4	Laundry	101,882	28,818	7,659	138,359		138,359	0	138,359			4
5	Heat and Other Utilities			247,188	247,188		247,188	1,499	248,687			5
6	Maintenance	81,727	40,021	29,081	150,829		150,829	21,934	172,763			6
7	Other (specify):*			40,226	40,226		40,226	1,252	41,478			7
8	TOTAL General Services	752,089	593,704	331,522	1,677,315	(28,328)	1,648,987	19,730	1,668,717			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600	0	3,600			9
10	Nursing and Medical Records	2,153,138	105,416	84,195	2,342,749	1,500	2,344,249	(1,599)	2,342,650			10
10a	Therapy	0		12,977	12,977		12,977	0	12,977			10a
11	Activities	117,759	6,997	2,467	127,223		127,223	0	127,223			11
12	Social Services	109,654		4,310	113,964		113,964	0	113,964			12
13	Nurse Aide Training			0				231	231			13
14	Program Transportation		6,857	0	6,857		6,857	0	6,857			14
15	Other (specify): DRUGS		4,199		4,199		4,199	0	4,199			15
16	TOTAL Health Care and Progra	2,380,551	123,469	107,549	2,611,569	1,500	2,613,069	(1,368)	2,611,701			16
	C. General Administration											
17	Administrative	77,439		183,600	261,039		261,039	160,306	421,345			17
18	Directors Fees			0				0				18
19	Professional Services			161,262	161,262	(1,500)	159,762	(97,034)	62,728			19
20	Dues, Fees, Subscriptions & Promotions			81,554	81,554		81,554	(51,603)	29,951			20
21	Clerical & General Office Expense	197,518	24,956	416,395	638,869		638,869	(287,345)	351,524			21
22	Employee Benefits & Payroll Taxes			559,343	559,343	28,328	587,671	0	587,671			22
23	Inservice Training & Education			0				0				23
24	Travel and Seminar			2,265	2,265		2,265	1,213	3,478			24
25	Other Admin. Staff Transportation			5,457	5,457		5,457	55	5,512			25
26	Insurance-Prop.Liab.Malpractice			170,227	170,227		170,227	1,419	171,646			26
27	Other (specify):*			0				34,543	34,543			27
28	TOTAL General Administration	274,957	24,956	1,580,103	1,880,016	26,828	1,906,844	(238,446)	1,668,398			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,407,597	742,129	2,019,174	6,168,900		6,168,900	(220,084)	5,948,816			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			71,460	71,460		71,460	(4,908)	66,552			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			60,989	60,989		60,989	4,399	65,388			32
33	Real Estate Taxes			331,991	331,991		331,991	3,526	335,517			33
34	Rent-Facility & Grounds			1,505,479	1,505,479		1,505,479	0	1,505,479			34
35	Rent-Equipment & Vehicles			15,818	15,818		15,818	14,669	30,487			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,985,737	1,985,737		1,985,737	17,686	2,003,423			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		34,472	23,978	58,450		58,450	(2,827)	55,623			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			180,072	180,072		180,072	0	180,072			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		34,472	204,050	238,522		238,522	(2,827)	235,695			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,407,597	776,601	4,208,961	8,393,159	0	8,393,159	(205,225)	8,187,934			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(11,178)	30		9
10	Interest and Other Investment Income	(131)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,230)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,725)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(6,429)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,492)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(49,476)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(94,502)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (170,313)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34,912)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (34,912)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (205,225)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name WEDGEWOOD NURSING PAVILION

IDPH 0035032

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(4,992)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	6,150
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	1,908
9	**Non-Straightline Depreciation**	(11,178)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(131)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(3,230)	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(1,725)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	(150)	20	**Line 16**	0
18	**Fines and Penalties**	(6,429)	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(3,492)	20	**Line 19**	(100,426)
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(53,110)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	(8,452)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(49,476)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	0	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(160,199)
30	**Donated Goods**	0	0	**Line 29**	(159,041)
31	**Amortization Expense**	0	0	**Line 30**	(53,430)
32	CONSULTING FEES	(100,652)	19	**Line 31**	0
33	DEFERRED MAINTENANCE	6,150	6	**Line 32**	(181)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(11,240)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(170,311)
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,955)	0	0	0	0	0	0	0	0	0	0	(4,955)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,499	0	0	0	0	0	0	0	0	1,499	5
6	Maintenance	6,150	0	7,657	8,127	0	0	0	0	0	0	0	21,934	6
7	Other (specify):*	0	0	216	0	1,036	0	0	0	0	0	0	1,252	7
8	**TOTAL General Services**	1,195	0	9,372	8,127	1,036	0	0	0	0	0	0	19,730	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,599)	0	0	0	0	0	(1,599)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	231	0	0	0	0	0	0	0	0	231	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	231	0	0	(1,599)	0	0	0	0	0	(1,368)	16
	C. General Administration													
17	Administrative	0	(183,600)	0	343,906	0	0	0	0	0	0	0	160,306	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(100,652)	0	3,618	0	0	0	0	0	0	0	0	(97,034)	19
20	Fees, Subscriptions & Promotions	(53,118)	0	1,515	0	0	0	0	0	0	0	0	(51,603)	20
21	Clerical & General Office Expenses	(6,429)	(379,055)	90,532	7,607	0	0	0	0	0	0	0	(287,345)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,213	0	0	0	0	0	0	0	0	1,213	24
25	Other Admin. Staff Transportation	0	0	55	0	0	0	0	0	0	0	0	55	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,419	0	0	0	0	0	0	0	0	1,419	26
27	Other (specify):*	0	0	12,000	0	22,543	0	0	0	0	0	0	34,543	27
28	**TOTAL General Administration**	(160,199)	(562,655)	110,352	351,513	22,543	0	0	0	0	0	0	(238,446)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(159,004)	(562,655)	119,955	359,640	23,579	(1,599)	0	0	0	0	0	(220,084)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,178)	0	6,270	0	0	0	0	0	0	0	0	(4,908)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(131)	0	4,530	0	0	0	0	0	0	0	0	4,399	32
33	Real Estate Taxes	0	0	3,526	0	0	0	0	0	0	0	0	3,526	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	14,669	0	0	0	0	0	0	0	0	14,669	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,309)	0	28,995	0	0	0	0	0	0	0	0	17,686	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(2,827)	0	0	0	0	0	(2,827)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	(2,827)	0	0	0	0	0	(2,827)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(170,313)	(562,655)	148,950	359,640	23,579	(4,426)	0	0	0	0	0	(205,225)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe WEDGEWOOD NURSING PAVILIO# 0025832 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 BOOKKEEPING FEES	$ 379,055	DYNAMIC HEALTHCARE CONSULTANT	%	$	(379,055)	1
2	V	17 MANAGEMENT FEES	182,600	DYNAMIC HEALTHCARE CONSULTANT			(182,600)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 562,655		%	$ *	(562,655)	14

Sum_6
-379055
-183600

* Total must agree with the amount recorded on line 30 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,499	$ 1,499	15	1499
16	V	6	REPAIRS & MAINT.		" " "	100.00%	7,657	7,657	16	7657
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	216	216	17	216
18	V	13	NURSES AIDE TRAINING		" " "	100.00%	231	231	18	231
19	V	19	PROFESSIONAL FEES		" " "	100.00%	3,618	3,618	19	3618
20	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	1,515	1,515	20	1515
21	V	21	CLERICAL & GENERAL		" " "	100.00%	90,532	90,532	21	90532
22	V	24	SEMINARS AND TRAVEL		" " "	100.00%	1,213	1,213	22	1213
23	V	25	ADMIN. STAFF TRANS		" " "	100.00%	55	55	23	55
24	V	26	INSURANCE		" " "	100.00%	1,419	1,419	24	1419
25	V	27	EMP BEN. - GEN ADMIN.		" " "	100.00%	12,000	12,000	25	12000
26	V	30	DEPRECIATION		" " "	100.00%	6,270	6,270	26	6270
27	V	32	INTEREST		" " "	100.00%	4,530	4,530	27	4530
28	V	33	REAL ESTATE TAXES		" " "	100.00%	3,526	3,526	28	3526
29	V	35	EQUIPMENT RENTAL		" " "	100.00%	14,669	14,669	29	14669
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 148,950	$ * 148,950	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Previe

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 8,127	$ 8,127	15	8127
16	V	10	NURSING CMP - SUE G.		" " "	100.00%			16	
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	65,594	65,594	17	65594
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	84,114	84,114	18	84114
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			19	
20	V	17	ADMIN. CMP. - A. STERN		" " "	100.00%	52,953	52,953	20	52953
21	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%	71,632	71,632	21	71632
22	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			22	
23	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	17,371	17,371	23	17371
24	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			24	
25	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			25	
26	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	19,119	19,119	26	19119
27	V	17	ADMIN. CMP. - A. STEINER		" " "	100.00%	6,254	6,254	27	6254
28	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	26,869	26,869	28	26869
29	V	21	CLERICAL CMP. - S. AARON		" " "	100.00%	7,607	7,607	29	7607
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 359,640	$ * 359,640	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,036	$ 1,036	15	1036
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16	
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	1,832	1,832	17	1832
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	2,133	2,133	18	2133
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19	
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%	7,406	7,406	20	7406
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21	
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	2,859	2,859	22	2859
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23	
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24	
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	2,620	2,620	25	2620
26	V	27	EMP. BEN. - A. STEINER		" " "	100.00%	1,038	1,038	26	1038
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	3,614	3,614	27	3614
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	1,041	1,041	28	1041
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 23,579	$ * 23,579	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

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STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6D
15	V	10a	THERAPY	$ 12,976	DYNAMIC REHAB CONSULTANTS LLC	100.00%	$ 12,976	$	15	
16	V	22	EMPLOYEE BENEFITS		" " "	100.00%			16	
17	V	39	ANCILLARY SERVICES	15,844	" " "	100.00%	15,844		17	
18	V								18	
19	V								19	
20	V	10	NURSING & MEDICAL SUPP		PHARMCOR LLC	100.00%			20	
21	V	11	ACTIVITIES		" "	100.00%			21	
22	V	22	EMPLOYEE BENEFITS		" "	100.00%			22	
23	V	39	ANCILLARY EXPENSE		" "	100.00%			23	
24	V								24	
25	V								25	
26	V	20	DUES, FEES & SUBSCRIPTION		LINCOLN MEDICAL SUPPLIES, INC.	100.00%			26	
27	V	10	MEDICAL SUPPLIES	6,077	" " "	100.00%	4,478	(1,599)	27	-1599
28	V	39	ANCILLARY EXPENSE	10,745	" " "	100.00%	7,918	(2,827)	28	-2827
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 45,642			$ 41,216	$ * (4,426)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	ABE STERN	VICE PRESIDENT	ADMINISTRATIVE			SCHEDULE ATTACHI		CONSULT	$ 52,953	17-7	1
2	MARSHALL MAUER	VICE PRESIDENT	ADMINISTRATIVE					SALARY	65,594	17-7	2
3	MAURICE AARON	SECRETARY	ADMINISTRATIVE					SALARY	84,114	17-7	3
4	SHIMON GOLDSTEIN		ADMINISTRATIVE					SALARY	71,632	17-7	4
5	SHARON AARON		CLERICAL					SALARY	7,607	21-7	5
6											6
7			SCHEDULE								7
8			ATTACHED								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 281,900		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC HEALTHCARE CONSULT
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	707,726	15	$ 10,055	$	105,502	$ 1,499	1
2	6	REPAIRS & MAINT	" "	707,726	15	51,362	16,071	105,502	7,657	2
3	7	EMP. BEN. - GEN. SVC.	" "	707,726	15	1,448		105,502	216	3
4	13	NURSES AIDE TRAINING	" "	707,726	15	1,550		105,502	231	4
5	19	PROFESSIONAL FEES	" "	707,726	15	24,272		105,502	3,618	5
6	20	DUES & SUBSCRIPTIONS	" "	707,726	15	10,163		105,502	1,515	6
7	21	CLERICAL & GENERAL	" "	707,726	15	607,305	465,093	105,502	90,532	7
8	24	SEMINARS & TRAVEL	" "	707,726	15	8,134		105,502	1,213	8
9	25	ADMIN. STAFF TRANS.	" "	707,726	15	372		105,502	55	9
10	26	INSURANCE	" "	707,726	15	9,517		105,502	1,419	10
11	27	EMP.BEN. - GEN. ADMIN.	" "	707,726	15	80,498		105,502	12,000	11
12	30	DEPRECIATION	" "	707,726	15	42,057		105,502	6,270	12
13	32	INTEREST	" "	707,726	15	30,386		105,502	4,530	13
14	33	REAL ESTATE TAXES	" "	707,726	15	23,654		105,502	3,526	14
15	35	EQUIPMENT RENTAL	" "	707,726	15	98,401		105,502	14,669	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 999,174	$ 481,164		$ 148,950	25

Print Previe

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Print Page 8

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC HEALTHCARE CONSULT
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 54,000	$ 54,000	6	$ 8,127	1
2	10	NURSING - SUE G	" "	40	1	32,209	32,209		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	14	435,842	435,842	6	65,594	3
4	17	ADMIN. CMP. - M. AARON	" "	45	14	558,156	558,156	7	84,114	4
5	17	ADMIN. CMP. - F. AARON	" "	50	7	160,040	160,040		0	5
6	17	ADMIN. CMP. - A. STERN	" "	8	14	351,664		1	52,953	6
7	17	ADMIN. CMP. - S. GOLDST	" "	50	3	179,079	179,079	20	71,632	7
8	17	ADMIN. CMP. - S. KOPLIN	" "	45	10	67,732	67,732		0	8
9	17	ADMIN. CMP. - D. MAGAFA	" "	45	10	82,127	82,127	10	17,371	9
10	17	ADMIN. CMP. - E. CASSON	" "	45	2	47,882	47,882		0	10
11	17	ADMIN. CMP. - S. BOGEN	" "	45	3	119,320	119,320		0	11
12	17	ADMIN. CMP. - S. LEVY	" "	55	14	126,974	126,974	8	19,119	12
13	17	ADMIN. CMP. - A. STEINER	" "	45	14	41,511	41,511	7	6,254	13
14	17	ADMIN. CMP. - NON-OWNI	" "	45	14	178,292	178,292	7	26,869	14
15	21	CLERICAL CMP. - S. AARO	" "	40	14	50,548	50,548	6	7,607	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,485,376	$ 2,133,712		$ 359,640	25

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STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC HEALTHCARE CONSULT
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost. Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 6,887	$	6	$ 1,036	1
2	15	EMP BEN - SUE G.	" "	40	1	2,883			0	2
3	27	EMP BEN - M. MAUER	" "	40	14	12,175		6	1,832	3
4	27	EMP BEN - M. AARON	" "	45	14	14,155		7	2,133	4
5	27	EMP BEN - F. AARON	" "	50	7	19,744			0	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	18,514		20	7,406	6
7	27	EMP BEN - S. KOPLIN	" "	45	10	14,423			0	7
8	27	EMP BEN - D. MAGAFAS	" "	45	10	13,516		10	2,859	8
9	27	EMP BEN - E. CASSON	" "	45	2	10,284			0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	3	7,029			0	10
11	27	EMP BEN - S. LEVY	" "	55	14	17,400		8	2,620	11
12	27	EMP BEN - A. STEINER	" "	45	14	6,891		7	1,038	12
13	27	EMP BEN - NON-OWNER	" "	45	14	23,984		7	3,614	13
14	27	EMP BEN - S. AARON	" "	40	14	6,917		6	1,041	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,802	$		$ 23,579	25

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STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC REHAB CONSULTANTS L
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost. Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						12,976	2
3	22	EMPLOYEE BENEFITS	" "							3
4	39	ANCILLARY SERVICES	" "						15,844	4
5										5
6										6
7		PHARCOR LLC								7
8	10	NURSING & MEDICAL SUP	DIRECT ALLOCATION							8
9	22	EMPLOYEE BENEFIT	" "							9
10	39	ANCILLARY EXPENSE	" "							10
11										11
12										12
13		LINCOLN MEDICAL SUPPLIES								13
14	20	DUES, FEES & SUBSCRIPT	DIRECT ALLOCATION							14
15	10	MEDICAL SUPPLIES	" "						4,478	15
16	39	ANCILLARY EXPENSE	" "						7,918	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 41,216	25

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI			WORKING CAPITAL	DEMAND			1,571,000		PRIME+	60,989	6
7												7
8	RELATED PARTY	X									4,530	8
9	TOTAL Facility Related						$	$ 1,571,000			$ 65,519	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,571,000			$ 65,519	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	341,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	331,991	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,009)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	341,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	331,991	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	339,515	8
	1996	347,869	9
	1997	328,404	10
	1998	334,234	11
	1999	331,991	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,056 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7+BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8					66,128	1,696	35	1,889	193	13,855	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENT			1989	71,162	2,259	31.5	2,259		24,930	9
10	LEASEHOLD IMPROVEMENT			1990	550	17	31.5	17		187	10
11	LEASEHOLD IMPROVEMENT			1990	122,091	3,877	20	6,105	2,228	61,868	11
12	LEASEHOLD IMPROVEMENT			1991	37,806	1,200	20	1,890	690	17,873	12
13	LEASEHOLD IMPROVEMENT			1992	33,756	1,071	31.5	1,071		9,208	13
14	LEASEHOLD IMPROVEMENT			1993	6,962	221	31.5	221		1,736	14
15	LEASEHOLD IMPROVEMENT			1993	29,154	747	39	747		5,457	15
16	LEASEHOLD IMPROVEMENT			1994	38,253	981	39	981		6,432	16
17	BOILER REPAIR			1995	22,647	31	39	31		375	17
18	GREASE TRAP REPAIR			1995	2,000	51	39	51		300	18
19	WALL PAPER			1995	5,285	38	39	38		269	19
20	ROOF REPAIR			1995	3,400	243	39	243		1,270	20
21	WALKING COOLER REPAIR			1995	1,455	124	39	124		643	21
22	WATER COMPRESSOR			1995	843	84	39	84		426	22
23	SPRINKLER SYSTEM			1995	9,000	163	39	163		844	23
24	HANDRAIL & BUMPER GUARD			1995	657	496	39	496		2,482	24
25	WALK IN FREEZER			1995	8,296	22	39	22		261	25
26	GENERATOR REPAIR			1995	4,878	248	39	248		1,297	26
27	BOILER REPAIR			1996	8,945	229	39	229		953	27
28	WALLPAPER			1996	3,236	83	39	83		398	28
29	ROOF REPAIR			1996	4,275	110	39	110		499	29
30	HEAT, HOT WATER PUMP REPAIR			1996	3,729	96	39	96		399	30
31	BOILER, HEATER, BURNER, HVAC REPAIRS			1997	19,222	493	39	493		1,847	31
32	TUCKPOINTING			1997	82,900	2,126	39	2,126		7,709	32
33	CARPET & TILE			1997	6,584	169	39	169		613	33
34	CEILING TILES, LIGHT FIXTURES, WINDOW TREATMEN			1997	9,822	252	39	252		914	34
35	DOORS & ENTRYWORK			1997	10,164	260	39	260		943	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 17,387		$ 20,498	$ 3,111	$ 163,988	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ALTENATOR, COMPRESSOR, AIR HANDLER, BOILER RE			1998	12,287	315	39	315		797	9
10	SPRINKLER, FIRE ALARM SYSTEM, DAMPERS			1998	56,527	1,450	39	1,450		3,673	10
11	CUBICLE CURTAINS, WINDOW TREATMENT REPAIR			1998	11,024	283	39	283		717	11
12	DOORS, DOOR HOLDERS, GLASS INSTALLATION			1998	11,128	285	39	285		721	12
13	CARPET, CORNER GUARDS			1998	2,804	72	39	72		174	13
14	ELEVATOR REPAIR			1998	7,028	180	39	180		451	14
15	FENCE WORK			1998	1,345	34	39	34		83	15
16	LIGHT FIXTURES			1998	3,652	94	39	94		233	16
17	ROOF REPAIR			1998	6,899	177	39	177		445	17
18	FIRE ALARM			1999	25,858	663	39	663		1,286	18
19	BOILER WORK			1999	5,723	147	39	147		252	19
20	CEILING INSTALL AND LIGHT			1999	12,053	309	39	309		512	20
21	COOLING TOWER			1999	4,134	106	39	106		130	21
22	CORNER GUARDS			1999	3,643	93	39	93		134	22
23	COVE BASE AND FLOOR PATCH			1999	14,870	381	39	381		684	23
24	DOORS			1999	14,081	361	39	361		622	24
25	PLUMBING WORK			1999	2,524	65	39	65		87	25
26	NURSES STATION			1999	5,800	149	39	149		230	26
27	HOT WATER HEATER			1999	17,542	450	39	450		767	27
28	LANDSCAPING			1999	5,126	131	39	131		238	28
29	REHAB WORK			1999	47,639	1,221	39	1,221		1,983	29
30	ROOF WORK			1999	15,600	400	39	400		617	30
31	WINDOW WORK			1999	20,059	515	39	515		934	31
32	FIRE ALARM REPAIR/HEAT DETECTOR			2000	7,420	170	27.5	170		170	32
33	CEILING TILE			2000	1,237	29	27.5	29		29	33
34	DOOR/GLASS			2000	2,894	68	27.5	68		68	34
35	BOILER REPAIR			2000	3,880	88	27.5	88		88	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 8,236		$ 8,236	$	$ 16,125	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	GAS CONTROL/WATER CLEANING SYS/EXHAUST FAN R			2000	3,915	93	27.5	93		93	9
10	ROOF REPAIR			2000	1,665	39	27.5	39		39	10
11	LIGHT FIXTURES			2000	1,781	254	20	45	(209)	45	11
12											12
13											13
14											14
15											15
16											16
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 386		$ 177	$ (209)	$ 177	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 354,357	$ 42,811	$ 32,132	$ (10,679)	10-15 YRS	$ 159,785	37
38	Current Year Purchases	28,761	4,336	1,438	(2,898)	10 YRS	1,438	38
39	Fully Depreciated Assets	4,850					4,850	39
40	RELATED PARTY	38,762	4,118	3,676	(442)		17,325	40
41	TOTALS	$ 426,730	$ 51,265	$ 37,246	$ (14,019)		$ 183,398	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RELATED PARTY			$ 2,370	$ 456	$ 395	$ (61)		$ 395	42
43										43
44										44
45										45
46	TOTALS			$ 2,370	$ 456	$ 395	$ (61)		$ 395	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	#VALUE!	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	77,730	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	66,552	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	(11,178)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	364,083	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BTNH LTD. PARTNERSHIP
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		328	11/01/89	$ 1,505,479			3
4	Additions							4
5								5
6								6
7	TOTAL		328		$ 1,505,479 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/89
Ending 09/30/02

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ #######
13.	12/31/2002	$ #######
14.	12/31/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipm $ 5,265 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2000 LEXUS SUV	$ 594.00	$ 7,124	17
18		1999 HONDA ACCORD	307.00	3,683	18
19			######	(254)	19
20					20
21	TOTAL		$ 647.00	$ 10,553	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 4,650	$		$ 4,650	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				5,354			5,354	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				5,842			5,842	4
5	Physician Care	39-3	visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					22,405		22,405	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):	39 - 2 & 3					8,132	12,067		20,199	13
14	TOTAL				$		$ 23,978	$ 34,472		$ 58,450	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,498	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,542,002		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,978		6
7	Other Prepaid Expenses	6,185		7
8	Accounts Receivable (owners or related parties)	749,532		8
9	Other(specify): RE ESCROW	370,160		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,766,355	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	877,211		15
16	Equipment, at Historical Cost	387,968		16
17	Accumulated Depreciation (book methods)	(416,701)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	17,468		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(17,468)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	325		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 848,803	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,615,158	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 507,553	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,611,511		29
30	Accrued Salaries Payable	309,916		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,047		31
32	Accrued Real Estate Taxes(Sch.IX-B)	341,000		32
33	Accrued Interest Payable	12,660		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,805,687	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,805,687	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,809,471	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,615,158	$	48

***(See instructions.)**

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,054,745	1
2	Restatements (describe):		2
3	REPLACEMENT TAX	(18,920)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,035,825	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,134,846	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,361,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (226,354)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,809,471	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,467,117	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,467,117	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	57,527	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 57,527	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 131	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	DISCOUNTS	3,230	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,230	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 9,528,005	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,677,315	31
32	Health Care	2,611,569	32
33	General Administration	1,880,016	33
	B. Capital Expense		
34	Ownership	1,985,737	34
	C. Ancillary Expense		
35	Special Cost Centers	58,450	35
36	Provider Participation Fee	180,072	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,393,159	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,134,846	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 1,134,846	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number WEDGEWOOD NURSING PAVILION # 0035832 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,560	1,555	$ 47,569	$ 30.59	1
2	Assistant Director of Nursing	477	397	10,257	25.84	2
3	Registered Nurses	15,478	16,482	307,507	18.66	3
4	Licensed Practical Nurses	52,102	54,191	906,187	16.72	4
5	Nurse Aides & Orderlies	106,903	114,133	834,970	7.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,926	2,022	28,559	14.12	9
10	Activity Assistants	13,705	14,710	89,200	6.06	10
11	Social Service Workers	12,433	13,257	109,654	8.27	11
12	Dietician	1,960	2,221	39,047	17.58	12
13	Food Service Supervisor					13
14	Head Cook	6,176	6,835	61,826	9.05	14
15	Cook Helpers/Assistants	29,379	32,102	207,677	6.47	15
16	Dishwashers					16
17	Maintenance Workers	6,689	6,996	81,727	11.68	17
18	Housekeepers	37,468	39,569	259,930	6.57	18
19	Laundry	15,211	16,762	101,882	6.08	19
20	Administrator	2,025	2,218	77,439	34.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,321	19,016	197,518	10.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,717	5,028	46,648	9.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	325,530	347,494	$ 3,407,597 *	$ 9.81	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	411	$ 7,368	1-3	35
36	Medical Director	MONTHLY	3,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	96	5,580	10-3	39
40	Physical Therapy Consultant	181	6,344	10a-3	40
41	Occupational Therapy Consulta	80	2,783	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	110	3,850	10a-3	43
44	Activity Consultant	56	2,467	11-3	44
45	Social Service Consultant	80	4,310	12-3	45
46	Other(specify)				46
47	UR REVIEW	MONTHLY	1,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,014	$ 37,502		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	2,803	77,415	10-3	52
53	TOTAL (lines 50 - 52)	2,803	$ 77,415		53

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